



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Sentrix Pharmacy and Discount, L.L.C.

Respondent Name

Hartford Underwriters Insurance Company

MFDR Tracking Number

M4-16-3264-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

June 24, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Insurance carrier, Hartford Insurance Company, failed to take final action on the claim within the 45-day period set forth in TAC §133.240. Specifically the claim was submitted on 3/21/16 and it was received by the provider on 3/28/16 ... and no action was taken on the claim). Sentrix resubmitted the bills for reconsideration on 5/12/16 and it was received by the provider on 5/17/16 ... Again, no action was taken on the claim."

Amount in Dispute: \$1,717.29

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Hartford received a partial request, not the entire compounding ingredient list; therefore, The Hartford requested information on two separate occasions per Texas Guidelines.

No response was received from the prescribing doctor, Mark Garza MD after 48 hours for each attempt (total of four days). The Hartford closed the retrospective request for lack of information; therefore, non-certified. Lack of information letter was faxed to the provider, with verbiage that includes opportunity for additional review when supporting information is received."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 21, 2016	Pharmacy Services - Compounds	\$1,717.29	\$1,717.29

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §133.210 sets out the documentation requirements for medical billing.
3. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of a medical bill.
4. 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical benefits.
5. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
6. The submitted documentation does not include an explanation of benefits.

Issues

1. Is the insurance carrier's reason for denial of payment supported?
2. Is Sentrix Pharmacy and Discount (Sentrix) entitled to reimbursement for the compound in question?

Findings

1. The requesting health care provider, Sentrix, is seeking reimbursement of \$1,717.29 for a compound dispensed on March 21, 2016. Hartford Underwriters Insurance Company (Hartford) denied the disputed compound with claim adjustment reason code 85 – "CLAIM NOT PROCESSED." In its position statement, Hartford asserted "The Hartford requested information on two separate occasions per Texas Guidelines. No response was received from the prescribing doctor, Mark Garza MD..."

28 Texas Administrative Code §133.240(d) states, "The insurance carrier may request additional documentation, in accordance with §133.210 of this title ..., not later than the 45th day after receipt of the medical bill to clarify the health care provider's charges."

28 Texas Administrative Code §133.210(d) states:

Any request by the insurance carrier for additional documentation to process a medical bill shall:

- (1) be in writing;
- (2) be specific to the bill or the bill's related episode of care;
- (3) describe with specificity the clinical and other information to be included in the response;
- (4) be relevant and necessary for the resolution of the bill;
- (5) be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider;
- (6) indicate the specific reason for which the insurance carrier is requesting the information; and
- (7) include a copy of the medical bill for which the insurance carrier is requesting the additional documentation.

The division finds that Hartford failed to support that a request for information was sent to the provider, in this case, Sentrix, pursuant to 28 Texas Administrative Code §133.240(d) with the specificity required in 28 Texas Administrative Code §133.210(d). The division concludes that the insurance carrier's denial is not supported. Therefore, the disputed compound will be reviewed for reimbursement.

2. 28 Texas Administrative Code §134.503 applies to the compounds in dispute and states, in pertinent part:
 - (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
 - (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
 - (A) Generic drugs: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \4.00 dispensing fee per prescription = reimbursement amount;
 - (B) Brand name drugs: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.09) + \4.00 dispensing fee per prescription = reimbursement amount;
 - (C) When compounding, a single compounding fee of \$15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection; or
 - (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
 - (A) health care provider; or

(B) pharmacy processing agent only if the health care provider has not previously billed the insurance carrier for the prescription drug and the pharmacy processing agent is billing on behalf of the health care provider.

The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately as required by 28 Texas Administrative Code §134.502(d)(2). Each ingredient is listed below with its corresponding reimbursement amount as applicable.

Ingredient	NDC & Type	Price/ Unit	Total Units	AWP Formula §134.503(c)(1)	Billed Amt §134.503 (c)(2)	Lesser of (c)(1) and (c)(2)
Compound Fee	NA	NA	NA	\$15.00	\$0.00	\$0.00
Amantadine 8%	38779041109 Generic	\$24.225	14.4 gm	\$436.05	\$348.79	\$348.79
Amitriptyline 2%	38779018908 Generic	\$18.24	3.6 gm	\$82.08	\$65.60	\$65.60
Baclofen 4%	38779038808 Generic	\$35.63	7.2 gm	\$320.67	\$256.56	\$256.56
Gabapentin 5%	38779246108 Generic	\$59.85	9.0 gm	\$673.31	\$538.71	\$538.71
Ketoprofen 10%	38779007805 Generic	\$10.45	18.0 gm	\$235.13	\$188.04	\$188.04
Versatile Base AWP Cream	51552134308 Generic	\$2.50	127.8 gm	\$399.38	\$319.59	\$319.59
					Total	\$1,717.29

The total reimbursement is therefore \$1,717.29. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$1,717.29.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor \$1,717.29, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

_____ Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	December 14, 2017 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.